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Towards a Better Connection: A Federally-Led Uniform Reimbursement Scheme for Telemedicine

Meredith Price

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Meredith Price*[1]

I. Introduction

Amazon.com turned twenty years old last year.[2] The company's success is driven, in large part, by the shift of consumers to online shopping,[3] which itself is the result of consumer's increasing demand for access, value, and convenience.[4] Much like online shopping has become the norm over the last two decades, the healthcare industry is undergoing a similar technological makeover. Telemedicine — broadly defined as the remote diagnoses and treatment of patients by way of electronic communications and technology — is rapidly redefining healthcare delivery, reducing costs, and improving patient outcomes.[5] Two recent studies indicated that in 2014 nearly ten million Americans used some form of telemedicine, and more than twenty-seven percent of healthcare consumers would choose to visit the doctor using a telehealth platform if one was available to them.[6]

On April 30, 2015, United Healthcare, the nation's largest health insurer by market share,[7] announced a partnership with three telemedicine companies to offer and reimburse video-

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[1] J.D. Candidate, 2017, Seton Hall University School of Law; B.A., Ramapo College of New Jersey. I would like to extend my sincere thanks to Professor John Jacobi for his guidance in writing this Comment. Readers should be aware that while the information in this Comment is current as of April 2016, the law in this field continues to change.

[2] Marcelo Prince & Sarah Slobin, *How 20 Years of Amazon Changed Retail*, WALL ST. J. (July 15, 2015), http://www.wsj.com/articles/how-20-years-of-amazon-changed-retail-1436998020.

[3] *Id.*

[4] *See* Suzanne Kapner, et al, *Malls Reels as Web Roars with Holiday Shopping*, WALL ST. J. (July 15, 2015), http://www.wsj.com/articles/malls-reel-as-web-roars-1450917888.

[5] Am. Telemedicine Assoc., *What is Telemedicine?*, http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.Vj5COq6rSRs.

[6] *See UnitedHealthcare Covers Virtual Care Physician Visits, Expanding Consumers' Access to Affordable Health Care Options*, UNITEDHEALTHCARE (April 30, 2015), http://www.uhc.com/news-room/2015-news-releasearchive/unitedhealthcare-covers-virtual-care-physician-visits (discussing results of a study conducted by the American Telemedicine Association and a Harris Poll survey).

[7] Evi Heilbrunn, *Top Insurance Companies*, U.S. NEWS & WORLD REPORTS (Nov. 5, 2014), http://health.usnews.com/health-news/health-insurance/articles/2013/12/16/top-health-insurance-companies.

based doctor visits for its members.[8] Other players in the health insurance market, including Oscar, WellPoint, and some BlueCross BlueShield plans, have recently adopted similar programs.[9] The latest market research indicates that the market for telemedicine in North America alone is expected to be worth more than $13 billion by the end of 2020.[10]

Telemedicine offers convenience, access, and immediacy to consumers, while freeing up valuable space in hospitals and other care facilities for patients who actually require it.[11] Unfortunately, various legal and policy barriers, including reimbursement, licensing, and privacy concerns have slowed the implementation of telemedicine.[12] Payment and reimbursement for services is frequently cited as one of the largest barriers to the widespread adoption of telemedicine,[13] and is the focus of this Comment.

This Comment will examine the current patchwork of various Medicaid programs and private insurance regulations with regard to telemedicine reimbursement at the state level, and argue for increased parity of payment and reimbursement for telemedicine across state, federal, and private health insurance platforms. Part II examines the history and benefits of telemedicine services and technology. Part III discusses the development of the current payment system, and the gaps and problems with the current system. Part IV identifies the need for the broad federal reform that is proposed in Part V. Congress can rapidly and dramatically expand telemedicine adoption in the United States through modest amendments to the federal Medicare statute and the

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[8] United Healthcare, *supra* note 6; Issie Lapowsky, *Video is about to Become the Way We All Visit the Doctor*, WIRED (Apr. 30, 2015), http://www.wired.com/2015/04/united-healthcare-telemedicine/.
[9] *Id.*
[10] Bernie Monegain, *Telemedicine Market to Soar Past $30B*, HEALTHCARE IT NEWS (Aug. 4, 2015), http://www.healthcareitnews.com/news/telemedicine-poised-grow-big-time.
[11] *See* Am. Hospital Assoc., *Realizing the Promise of Telehealth: Understanding the Legal and Regulatory Challenges*, TrendWatch (May 2015), *available at* http://www.aha.org/research/reports/tw/15may-tw-telehealth.pdf (last accessed Feb. 12, 2016).
[12] *See id.*
[13] *Id.*

Essential Health Benefits provision of the Patient Protection and Affordable Care Act.[14] More uniform reimbursement standards will support greater technological development, simplify billing procedures as healthcare companies expand to national business models, and will encourage more patients to use telemedicine services.

II. History and Benefits of Telemedicine

A. What is Telemedicine?

While there is no universally agreed-upon definition of telemedicine, the World Health Organization describes it as:

> [t]he delivery of health care services, where distance is a critical factor, by health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interest of advancing the health of individuals and their communities.[15]

Put simply, telemedicine is the electronic exchange of medical data, often but not necessarily in real-time, for the purpose of delivering healthcare services remotely.[16] The term "telehealth" typically reflects a broader definition that includes non-clinical, educational, and administrative services, whereas "telemedicine" usually refers to the delivery of clinical services,[17] but the terms "telemedicine" and "telehealth" are frequently used interchangeably.[18]

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[14] For the current provisions, see 42 U.S.C. § 18002 and 42 C.F.R. § 410.78 (2003).
[15] World Health Org., *A Health Telematics Policy in Support of WHO's Health-for-All Strategy for Global Health Development*, Oct. 1998, *available at* http://apps.who.int/iris/bitstream/10665/63857/1/WHO_DGO_98.1.pdf.
[16] Joseph Kvedar et al, *Connected Health: A Review of Technologies and Strategies to Improve Patient Care with Telemedicine and Telehealth*, 33 HEALTH AFFAIRS 194–99 (2014).
[17] Center for Connected Health Policy, *State Telehealth Laws and Medicaid Program Policies* , July 2015,, *available at* http://cchpca.org/sites/default/files/resources/STATE%20TELEHEALTH%20POLICIES%20AND%20REIMBURSEMENT%20REPORT%20FINAL%20%28c%29%20JULY%202015.pdf.
[18] *Id.* Consistent with their interchangeable use in general and in medical literature, the terms are also frequently used interchangeably in this Comment.

Telemedicine dates back more than fifty years.[19] In the late 1950s, the University of Nebraska began transmitting neurological exams across campus and later to a state mental hospital 112 miles away to provide speech therapy and consultations remotely.[20] Shortly thereafter, NASA developed a telemedicine program to monitor astronauts in space, and the United States Department of Defense implemented remote healthcare services for soldiers overseas.[21] Over the last decade, the concept of telemedicine has expanded from a simple teleconference in the office of a primary care physician with a specialist located some distance away to include 24/7 remote patient monitoring, intensive care units (referred to as "tele-ICUs"), store-and-forward diagnostic abilities, and remote medication management.[22]

Telemedicine incorporates technology including live video, store-and-forward diagnostic capabilities, and remote patient monitoring.[23] Live video is the most common and most predominantly reimbursed form of telemedicine.[24] It refers to the use of two-way interactive audio-video technology in real time to connect patients and healthcare providers.[25] Store-and-forward technology allows for the electronic transmission of patient information.[26] For example, an ophthalmologist specializing in diabetic-related retina deterioration can view digital images remotely rather than traveling across the country to visit patients, or requiring that patients travel to him.[27] This technology is also frequently used in the provider-to-provider context (i.e. primary care doctor to specialist), and generally does not occur in real time.[28] Remote patient monitoring collects and electronically transmits patient medical data, which allows medical

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[19] 3 Health L. Prac. Guide § 46:3 (2016)
[20] *Id.*
[21] *Id.*
[22] *See* Am. Telemedicine Assoc., *supra* note 5.
[23] Center for Connected Health Policy, *supra* note 18.
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] Health Law Prac. Guide, *supra* note 19.
[28] *Id.*

professionals to monitor the information and sometimes even intervene without ever physically seeing the patient.[29]

Telemedicine services span the medical field and are increasingly valuable, particularly in the costly and specialized care of critically ill or injured patients.[30] Telemedicine technology and applications are available in many fields of medicine, including pediatrics, cardiology, dermatology, infectious diseases, neurology, pathology, and psychiatry.[31] Tele-radiology is the first and, by far, the most used telemedicine service in the United States.[32] It is used both for non-critical diagnostic purposes, as well as for rapid diagnosis of traumatic injuries and strokes.[33] Telemedicine is also an important and promising innovation for stroke care. Specialists are available around the clock to provide enhanced diagnoses and treatment recommendations during the "golden" one to three-hour period during which patient outcome is drastically reliant.[34] Similarly, telemedicine for trauma and burn care supplies highly specialized care for critically injured patients who may otherwise be unable reach a trauma or burn center.[35] The tele-ICU model has consistently resulted in a reduction of mortality rates, the length of hospital stays, and the frequency of readmission.[36] Furthermore, Telemedicine has also proven itself useful in other areas, such as prisons and offshore oil-rigs, where additional cost savings and safety benefits are realized outside of the immediate healthcare context.[37]

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[29] *Id.*
[30] Ronald S. Weinstein, et al, *Telemedicine, Telehealth, and Mobile Health Applications that Work: Opportunities and Barriers*, 127 AM. J. MED. 183–87 (2014).
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] Weinstein, *supra* note 30; *see also* Illene MacDonald, *TeleICU Saves California Hospital Thousands, Improves Patient Satisfaction*, FIERCEHEALTH IT (May 5, 2015), *available at* http://fiercehealthit.com/story/teleicu-saves-california-hospital-thousands-improves-patient-satisfaction/2015-05-05.
[37] Adam William Darkins & Margaret Ann Carey, TELEMEDICINE AND TELEHEALTH: PRINCIPLES, POLICIES, PERFORMANCE, AND PITFALLS 6 (2000); *see also* Weinstein, *supra* note 30. Cost-savings are realized and public safety is protected by not having to transport prisoners to medical facilities. *Id.*

B. Benefits of Telemedicine

Nationwide, approximately twenty percent of Medicare patients are readmitted to the hospital within thirty days of discharge, yet it is estimated that more than seventy-five percent of those readmissions are due to avoidable circumstances.[38] Telemedicine has proved to be an economical and easily accessible way to manage health care delivery and improve patient outcomes.[39] Telemedicine adoption promises to be a key component of health care delivery, particularly with the development of cost-sharing health care programs, accountable service organizations, and value based payment mechanisms, which place considerable emphasis on patient outcomes and cost-effective services.[40]

Cost-sharing programs are on the rise as a result of the Patient Protection and Affordable Care Act.[41] Cost-sharing refers to any health payment system where the member pays for at least some portion of their medical services — often via a deductible or coinsurance.[42] New Medicaid and Medicare programs provide incentives to health care networks, referred to as Accountable Service Organizations, to reduce costs by allowing the networks to share in any savings achieved by way of successful implementation of various cost-saving initiatives.[43] Value-based payment mechanisms award hospitals that achieve high quality patient care

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[38] Stacey Force, *The Role of Telehealth in Reducing Readmissions*, Readmissions News (Aug. 2013), *available at* https://www.honeywelllifecare.com/wp-content/uploads/2013/08/Readmissions-News-Role-of-Telehealth-in-Reducing-Readmissions.pdf; *cf.* Am. Hospital Assoc., *The Promise of Telehealth for Hospitals, Health Systems and Their Communities*, TrendWatch (Jan. 2015), *available at* http://www.aha.org/research/reports/tw/15jan-tw-telehealth.pdf (discussing specific studies that show reduced readmissions of up to 51% with telehealth interventions).

[39] *The Promise of Telehealth for Hospitals, Health Systems and Their Communities*, *supra* note 38.

[40] *See* Julia Adler-Milstein, et al, Telehealth Among US Hospitals: Several Factors, Including State Reimbursement and Licensure Policies, Influence Adoption, 33 HEALTH AFFAIRS 207–15 (2014).

[41] *See* Laurie Tolch, *Cost-Sharing on the Rise Among Workers with Employer-Sponsored Health Plans*, Am. J. of Pharm. Benefits (Apr. 16, 2016), *available at* http://www.ajpb.com/articles/costsharing-on-the-rise-among-workers-with-employersponsored-health-insurance.

[42] Appendix D, Health Law Prac. Guide.

[43] *Id.*

outcomes.[44] Accordingly, telemedicine expansion, and its associated cost savings and improved patient outcomes, is significantly beneficial to patients, providers, and insurers.

Dignity Health Woodland Memorial Hospital is a 108-bed community medical center in California.[45] When the hospital implemented a tele-ICU unit, the hospital saw a sixty percent reduction in mortality rates, a sixty percent reduction in re-intubation, a forty percent reduction in emergency transfers, and a ten percent reduction in intensive care unit transfers.[46] A year after implementation, the hospital's patient satisfaction score was ninety-one percent.[47] Indeed, Patient satisfaction is one of the most frequently studied and reported measures of telemedicine success.[48] One study found that ninety three percent of patients were satisfied with their dermatology treatment even though they never actually met with a dermatologist.[49]

Dignity Health also estimated that it would cost $300,000 to $500,000 per year for just one additional ICU intensivist.[50] So rather than hiring four or five additional doctors to provide full-time coverage for its eight bed ICU, the hospital launched a tele-ICU.[51] While a traditional model would cost the hospital more than $100,000 per bed per year, the tele-ICU model costs the hospital $30,000 per monitored bed per year.[52]

Elsewhere, the Lee Memorial Health System in Fort Myers, Florida — the fourth-largest public health system in the country — implemented a pilot program in 2010 aimed at expanding the use of remote patient monitoring.[53] After thirty-two months, the hospital reported that the

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[44] *Id.*
[45] MacDonald, *supra* note 36.
[46] *Id.*
[47] *Id.*
[48] Kristen Rabe Smolensky, *Telemedicine Reimbursement: Raising the Iron Triangle to a New Plateau*, 13 HEALTH MATRIX 371, 393–93 (2003).
[49] *Id.*
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] Force, *supra* note 38.

technology helped avoid approximately 950 hospital readmissions, with an estimated cost savings of more than $5.3 million.[54] Vidant Health, a company that operates hospitals and other health care facilities in North Carolina, instituted remote patient monitoring for patients with congestive heart failure, diabetes, and high blood pressure in 2012.[55] In 2013, hospital admissions for these patients fell by seventy-four percent.[56] During the first eight months of 2014, readmissions were down fifty-four percent from the same period a year earlier.[57] In 2014, approximately thirteen percent of congestive heart failure patients participating in a similar program at the University of Pittsburgh Medical Center were readmitted to the hospital within thirty days of discharge, compared with twenty percent of patients with the same condition who did not participate in the telemedicine program.[58]

These anecdotes indicate that telemedicine promises to reduce the costs of healthcare delivery and to improve patient outcomes. Empirical studies have also shown significant cost savings as treatment via telemedicine decreases cost compared to traditional methods of healthcare delivery, and often helps to avoid some of the costly complications associated with chronic illnesses.[59]

Healthcare is the largest industry in the United States, with total healthcare expenditures exceeding $2.3 trillion in 2008 and representing 16.2 percent of the nation's Gross Domestic Product.[60] Thus, any cost savings is significant savings. A study conducted by the Alliance for Connected Care revealed that the average cost of a telehealth visit costs an average of $40–50,

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[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *See* Rashid Bashir et al., *Telemedicine for Chronic Disease Management*, 20 TELEMED. & E-HEALTH 769, 793 (2014).
[60] National Health Expenditures 2009 Highlights, Ctrs. for Medicare & Medicaid Servs., http://cms.hhs.gov/NationalHealthExpendData/downloads/highlights.pdf.

whereas an in-office visit is estimated to cost $136–176.[61] Medicare reimburses for covered telehealth services at the same rate as in-office visits.[62] At a similar savings percentage, Medicare could save an average of about $45 per virtual visit.[63] There are also additional costs associated with healthcare delivery beyond those that are immediately recognizable, such as payment for medical equipment and staff training, which telemedicine is able and poised to help reduce.

Telemedicine is also a substantially important tool for increasing access to healthcare, particularly for patients who live in rural areas, or areas that lack an adequate amount of healthcare professionals.[64] The United States is facing a significant shortage in the number of primary care physicians.[65] These doctors are cited as one of the most important lines of defense against the rising costs of healthcare, both immediately recognizable and with respect to the health of the community and the public at large.[66]

III. Payment—Past and Present

Notwithstanding the significant benefits to telemedicine, the current payment system is one reason for what has been a relatively slow uptake of telemedicine services, despite the rapid pace of technological development in the area.[67] At the federal level, Medicare does provide reimbursement for telemedicine services in some circumstances, and there is proposed legislation

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[61] *Study: Virtual Health Care Visits Cost Less Than In-Office Care*, iHealthBeat (Dec. 15, 2014), *available at* http://www.ihealthbeat.org/articles/2014/12/15/study-virtual-health-care-visits-cost-less-than-inofice-care?view=print.
[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] *UnitedHealthcare Covers Virtual Care Physician Visits, Expanding Consumers' Access to Affordable Health Care Options*, UNITEDHEALTHCARE (April 30, 2015), http://www.uhc.com/news-room/2015-news-releasearchive/unitedhealthcare-covers-virtual-care-physician-visits.
[66] *Id. See also* Smolensky, *supra* note 48 at 410–13 (discussing the economic externalities and public policy considerations underscoring the need for a government-driven telemedicine reimbursement policy).
[67] *See* Deborah C. Baker & Lynn F. Bufka, *Preparing for the Telehealth World: Navigating Legal, Regulatory, Reimbursement, and Ethical Issues in an Electronic Age*, 42 PROF. PSYCH. 405 (2011).

to expand that coverage.[68] However, the current Medicare framework has substantial limitations. For example, although tele-radiology and tele-dermatology services have been proved to be cost effective, Medicare does not reimburse for these services.[69]

Medicaid reimbursement varies significantly depending upon the state administering the program, and has managed in many states to see the most rapid expansion in this area.[70] Nonetheless, Medicaid programs vary significantly and also often include substantial limitations.[71] Private payer coverage varies from state to state and insurer to insurer.[72] While many private insurers offer some level of reimbursement for telemedicine services, there remains significant room for improvement.[73]

Many federal laws designed to affect telemedicine reimbursement have not been successful, so states have attempted to take the lead in telemedicine reimbursement schemes.[74] In 2015, more than 200 telehealth related bills were introduced in state and federal legislative sessions, the majority of which addressed reimbursement and other barriers to increased telehealth adoption.[75] Ultimately, it is the gaps in which services are coverage and which are not, and the lack of payment parity across the federal, state, and private payer lines that is responsible for slowing the pace of telemedicine adoption in the United States.[76]

The current reimbursement framework across Medicaid, Medicare, and private payers is inadequate largely because of the lack of clarity and consistency between various laws and

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[68] Center for Connected Health Policy, *supra* note 18; *see* Medicare Telehealth Parity Act of 2015, H.R. 2948, 114th Cong. (2015–2016).
[69] *See* Smolensky, *supra* note 48 at 389.
[70] Center for Connected Health Policy, *supra* note 18.
[71] *See id.*
[72] *Id.*
[73] *Id.*
[74] Mary Schmeida and Ramona McNeal, *State Policy Action on Medicaid Telemedicine Reimbursement Laws*, 5 Health Policy and Tech. 32, 33 (2015).
[75] *Id.*
[76] Baker, *supra* note 67.

regulations.[77] At present, Medicare reimbursement is limited to specific geographic locations, originating sites, and eligible services and providers.[78] Telemedicine is only reimbursed for patients living in a Rural Professional Shortage Area or non-Metropolitan Statistical Area.[79] Additionally, patients may only receive services from an eligible originating site, such as a doctors' office, hospital, or clinic, and coverage is only provided for real-time services.[80] Thus, Medicare patients generally do not benefit from remote patient monitoring or store and forward diagnostics, and patients cannot avail themselves of telemedicine from home.[81] Medicaid coverage and reimbursement varies from none, to some, to comprehensive on a state by state basis.[82] Similarly, in the private-payer realm, most of the state-adopted telemedicine parity laws leave the determination of whether to reimburse telemedicine services at the same or reduced rate as in-person services up to the payer.[83]

The Balanced Budget Act of 1997 ("BBA") was the first federal law to mandate reimbursement of telemedicine services in the Medicare context.[84] The reimbursement scheme was frought with limitations, however, and between January 1999 and September 2000, Medicare reimbursed only a total of 301 telemedicine claims with a total value of $20,000.[85] In December 2000, Congress enacted the Benefits Improvement and Protection Act ("BIPA"), which reduced some of the limitations on Medicare reimbursement for telemedicine services, but

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[77] *See* Schmedia and McNeal, *supra* note 74.
[78] *Id.*
[79] 42 C.F.R. § 410.78(b)(4) (West 2015).
[80] Baker, *supra* note 67.
[81] *Id.*
[82] Center for Connected Health Policy, *supra* note 18.
[83] *Id.* Additionally, many state plans include opt-out provisions for certain small group and worker's compensation plans. *See* Latoya Thomas & Gary Capistrant, *State Telemedicine Gaps Analysis*, Am. Telemedicine Assoc. (May 2015), *available at* http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis---coverage-and-reimbursement.pdf?sfvrsn=10.
[84] *Id.*
[85] Smolensky, *supra* note 48 at 375–76.

kept and in some instances strengthened other shortfalls.[86] In particular, BIPA provided for reimbursement of telehealth services only in designated rural health professional shortage areas, and only to patients receiving services at one of five types of provider settings.[87] Patients were required to be located at a doctor's office, a hospital, a rural health clinic, a skilled nursing facility, or a community mental health center.[88] This prevented realization of the potential for cost-savings associated with decreasing patients' need to travel to receive healthcare, and the improved outcomes seen when patients are able to receive care from home.[89]

In 2008, the Medicare Improvements for Patients and Providers Act relaxed more of the restrictions, adding three additional provider settings that may serve as originating sites.[90] Patients may now access care from a critical access hospital,[91] a federally qualified health center,[92] or a hospital-based or critical access dialysis facility.[93] In 2014, the Centers for Medicare & Medicaid Services ("CMS") slightly expanded the geographic reach for covered telehealth services.[94] Reimbursement remains limited, however, to patients in specific geographic locations — largely rural, underserved communities — receiving services at approved sites, and to live-video services only.[95]

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[86] *Id.*
[87] *Realizing the Promise of Telehealth*, *supra* note 11.
[88] *Id.*
[89] *See* Force, *supra* note 38.
[90] *Realizing the Promise of Telehealth, supra* note 11.
[91] Critical access hospitals are certified as meeting a set of Medicare eligibility rules and conditions, including location in a rural area at least thirty-five miles away from any other hospital, providing 24/7 emergency care, and having no more than twenty-five inpatient beds. 42 U.S.C. § 1395i-4(c)(2)(B).
[92] Federally qualified health centers receive grants under section 330 of the Public Health Service Act and qualify for enhanced Medicare reimbursement by way of location in an underserved area, providing comprehensive medical services, and offering a sliding-fee scale for those services. 42 U.S.C. § 1395x(aa)(4); *see* 42 C.F.R. § 405.2430.
[93] *Realizing the Promise of Telehealth, supra* note 11.
[94] *Id.*
[95] Center for Connected Health Policy, Centers for Medicare & Medicaid Services, *Your Medicare Coverage*,

The current Medicare framework still only reimburses for live video services.[96] There is no coverage for remote patient monitoring or store-and-forward services.[97] Medicare also limits the types of healthcare professionals who can provide telehealth services, and restricts reimbursement to services provided in specific facilities in remote geographic areas.[98] Patients must be in a designated rural health professional services area or a county outside of a metropolitan statistical area.[99] Providers are limited to physicians, nurse practitioners, physician's assistants, nurse-midwives, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologists and clinical social workers, and registered dieticians or nutritional professionals.[100] Relying on the definition of telehealth provided by BIPA, Medicare limits telehealth reimbursement to professional consultations, office visits, psychiatry services, and additional services only as specified by the Secretary.[101] Additional covered services are added on a case-by-case basis, and at a much slower pace than the technology and resources would otherwise allow.[102] In 2015, out of the more than ten thousand Medicare covered services, only seventy-five individual services are recognized as reimbursable by Medicare when delivered via telehealth as opposed to the traditional face-to-face model.[103]

Medicaid provides health care services to low income families and individuals.[104] State governments are primarily responsible for managing the programs, but the federal government establishes minimum requirements that states must follow in order to receive federal Medicaid

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[96] *Teleheath and Medicare*, CENTER FOR CONNECTED HEALTH POLICY, http://cchpca.org/telehealth-and-medicare (last visited Sept. 12, 2015).
[97] *Id.*
[98] *Id.*
[99] *Id.*
[100] *Id.*
[101] *Realizing the Promise of Telehealth*, *supra* note 11.
[102] *Id.*
[103] *Id.*
[104] Baker, *supra* note 67.

funding.[105] Because federal law does not mandate reimbursement for telemedicine in the Medicaid realm, it is up to each state to decide if and to what extent it will reimburse for these services.[106] As a result, the type and scope of services, if any, that are eligible for reimbursement varies widely from state to state.[107] For example, at present, Medicaid programs in forty-seven states and the District of Columbia will reimburse for doctor-patient visits conducted via live video conferencing; however, only sixteen states reimburse for remote patient monitoring, and merely nine states offer some level of reimbursement for store-and-forward services.[108]

Finally, while some private insurance will reimburse for telehealth services, it is not a federal requirement for these providers to do so.[109] Currently twenty-eight states and D.C. have passed and implemented laws related to private-payer reimbursement, but the laws vary in terms of the extent of coverage.[110] Often, to the extent the laws mandate private payer reimbursement for telehealth services, the laws only require reimbursement for services that would otherwise be covered in the traditional face-to-face context, and not always at the same rate.[111] Moreover, geographic limitations mean that patients with similar medical needs may have significantly different treatment options based on nothing other than whether the patient lives in a remote area or urban center.[112]

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[105] *Id.*
[106] *Id.*
[107] *See* Center for Connected Health Policy, *supra* note 18.
[108] *Id.*
[109] *Id.*
[110] *Teleheath Medicaid & State Policy*, CENTER FOR CONNECTED HEALTH POLICY, http://cchpca.org/telehealth-medicaid-state-policy (last visited Sept. 12, 2015). Four states have passed private payer reimbursement laws that are not yet effective. *Id.*
[111] Baker, *supra* note 67.
[112] *Id.*

In 2015, Washington enacted a broad telehealth parity law.[113] The law requires health plans to cover services delivered via "telemedicine" (videoconferencing and direct patient-to-doctor services) and store and forward services if: (1) the service is covered when delivered in person; (2) the service is medically necessary; and (3) the service is recognized under the Affordable Care Act as an essential health benefit.[114] The law does, however, have important limitations, including that it does not provide for coverage of telehealth methods that do not include a video component (such as remote medication management or store-and-forward services), and does not explicitly require that payment rates for telemedicine match rates for the same services provide in person.[115] Arkansas' law is significantly narrower; it covers physician-rendered services only, and even then only if the patient has previously established a face-to-face relationship with that physician.[116] By contrast, the law in New York mandates that many telehealth providers be reimbursed at the same rate as in-person providers, and includes psychologists, speech language pathologists, and midwives among its list of telehealth providers entitled to reimbursement.[117] Overall, states appear to be adopting both parity laws and restrictions on reimbursement, often at the same time, adding to the confusing patchwork of reimbursement schemes.

IV. The Reimbursement Barrier

In 2012, approximately 42% of hospitals in the United States offered some form of telemedicine service;[118] however, the lack of a clear, consistent, and comprehensive reimbursement policy is frequently cited as one of the largest obstacles to further expansion and

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[113] Philip Peisch, *Several States Enact Telehealth Parity Laws in 2015*, NAT'L L. REV. (June 3, 2015), *available at* http://www.natlawreview.com/article/several-states-enact-telehealth-parity-laws-2015.
[114] *Id.*
[115] *Id.*
[116] *Id.*
[117] *Id.*
[118] Adler-Milstein, *supra* note 40.

adoption of telemedicine.[119] In one survey, conducted in 2014, 84% of health care executives considered telemedicine important to their organization, yet 41% reported that they are not reimbursed at all for the telemedicine services they provide.[120] State policies on reimbursement for telemedicine services affect how likely hospitals are to invest in the technology and offer these services.[121] In particular, reimbursement policies that clarify regulations and explicitly require reimbursement for telemedicine services at the same rate as face-to-face services are associated with a greater likelihood of telemedicine adoption.[122]

Hospitals and other medical facilities in states that presently provide no reimbursement coverage for telemedicine are, naturally, reluctant to invest in telemedicine technology.[123] Developers of the medical devices, technological platforms, and information technology, along with companies aiming to connect patients and doctors to facilitate increased adoption of telehealth services are hindered by the current state-by-state regulatory framework. Furthermore, the present reimbursement scheme imposes various restrictions on where, for whom, and for what telemedicine services may be utilized, and precludes access to telemedicine services to many patients for whom the services would be most helpful.[124]

Telemedicine reimbursement is fragmented, and its failure to keep pace with technology to realize the potential for improving and expanding health care delivery in the United States underscores the need for a more uniform model of coverage. In developing a plan to increase telemedicine adoption by way of improving reimbursement policies, it will be important to focus on broad legislation rather than continued piecemeal expansion for individual services or

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[119] *E.g.*, Baker, *supra* note 67; *Realizing the Promise of Telehealth*, *supra* note 11.
[120] Nathaniel M. Lacktman & Lawrence W. Vernaglia, *2014 Telemedicine Survey Executive Summary*, Foley & Lardner LLP (Nov. 11, 2014), http://www.foley.com/2014-telemedicine-survey-executive-summary/.
[121] *Id.*
[122] *Id.*
[123] Adler-Milstein, *supra* note 40.
[124] *See* Weinstein, *supra* note 30.

technologies.[125] Rather than limiting coverage to specific services, medical professionals, or medical conditions, broad policies give hospitals the ability to choose which services and technologies they will use based on their own service models.[126] This, in turn, makes it more likely that hospitals will agree to make such a substantial investment.[127]

Even where companies have made substantial investments in the technology and resources to develop and implement telemedicine programs, state laws may interfere.[128] Teladoc is a telecommunications company in Texas that connects members to board certified physicians through an on-demand platform.[129]

> Once a Teladoc physician accepts the [patient's] request for consultation, the physician reviews the requesting registrant's information and medical records through the website, then calls the registrant by telephone and consults with him or her. Based on the medical records and history, reported symptoms, and other information the physician elicits during the consultation, the physician dispenses medical advice, including referring the registrant to a physician's office, dentist, or emergency room. When deemed appropriate, the physician can prescribe certain medications.[130]

Although the consultation and referral process is nearly identical to the traditional brick-and-mortar model of healthcare delivery, the Texas Medical Board issued a letter to Teladoc notifying the company that the Board considered Teladoc and its physicians in violation of a state requirement that physicians meet "face-to-face" with patients before prescribing medication.[131] Teladoc filed a complaint against the Board, arguing that the rule violates antitrust provisions in the Sherman Act because it causes "increased prices, reduced choice, reduced

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[125] Adler Milstein, *supra* note 40.
[126] *Id.*
[127] *Id.*
[128] *See generally* Caroline M. Poma, *Telemedicine: A Theraputic Prescription for Our Health Care System Contaminated by Old Economy Rules and Regulations*, 17 N.C. J.L. & TECH. ON. 74 (2016).
[129] *Teladoc, Inc. v. Texas Medical Bd.*, 112 F.Supp.3d 529, 533 (W.D.Tx. May 29, 2015).
[130] *Id.*
[131] *Id.* at 533–34.

access, reduced innovation, and a reduced overall supply of physician services."[132] Judge Robert Pitman of the United States District Court for the Western District of Texas issued an injunction against enforcement of the rule, finding that Teladoc was likely to succeed on the merits of its antitrust action.[133] The case remains in active litigation,[134] but the injunction itself is notable because the court appeared to embrace the same considerations of healthcare costs, on-demand access, and patient choice that illustrate the need for an expansive, national telemedicine policy.[135]

Several provisions in the Patient Protection and Affordable Care Act of 2010 ("ACA") already authorize or direct federal health officials to improve the implementation of telemedicine services and practices.[136] In particular, the ACA created the Center for Medicare & Medicaid Innovation ("CMMI") to develop and implement innovative payment and delivery methods to improve access to heath care and reduce associated costs.[137] The ACA also requires CMS to penalize hospitals for significant readmissions.[138] Remote monitoring, a service not frequently reimbursed at present, has been shown to reduce admissions and improve patient outcome.[139] Value based payment models are also on the rise; these models create incentives for hospitals to

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[132] *Id.* at 534, 537.
[133] *Id.*
[134] The Medical Board has petitioned the Fifth Circuit to review Judge Pitman's December 2015 decision that the Medical Board is not immune from the antitrust claim. *See* Matthew Bultman, *Texas Medical Board To Appeal Teladoc Immunity Decision*, LAW360 (Jan. 16. 2016), http://www.law360.com/articles/744394/texas-medical-board-to-appeal-teladoc-immunity-decision.
[135] *See Teladoc*, *supra* note 129 at 537–540.
[136] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-48, 42 U.S.C. §§ 2703 (f)(2), 3021 (b)(2)(B)(v), 3021 (a)(b)(2)(B)(xvi), 3021 (b)(2)(B)(xix), 3021 (b)(2)(C)(iv), 3022(2)(G), & 3024(b)(1)(A)(vi) (2010).
[137] *Realizing the Promise of Telehealth*, *supra* note 11.
[138] Patient Protection and Affordable Care Act, Pub. L. No. 111-48, 42 U.S.C. § 3025 (establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to hospitals with significant readmissions).
[139] *See e.g.*, Hsueh-Fen Chen, et al, *Telehealth and Hospitalizations for Medicare Home Healthcare Patients*, 17 Am. J. of Managed Care 224 (2011).

reduce admissions and readmissions, and to improve the coordination of patient care between primary care physicians and specialists.[140]

One of the models that CMMI is testing is increased used of telehealth services to monitor high-risk, chronically-ill patients.[141] In March 2015, CMMI announced that through the Next Generation Accountable Care Organization, some patients will be able to seek a waiver of the Medicare geographic and practice setting restrictions.[142] The ACA also created an optional state Medicaid benefit to allow states to establish Health Homes. Health Homes are designed to "integrate and coordinate all primary, acute, behavioral health, and long-term services and supports" for Medicaid patients with chronic conditions.[143] In a guidance letter to state health officials, CMS explained that it "recognizes the importance of health information technology in furthering the aims of the health home model of service delivery," and while "CMS encourages States to consider utilizing technologies to provide health home services and improve care coordination across the care continuum,"[144] states remain responsible for determining the extent to which they will adopt telemedicine.[145] A similar addition to the Essential Benefits provision would make participation in the program, or a similar program, required rather than optional. Indeed, modest amendments to the federal Medicaid statute and the Affordable Care Act's Essential Health Benefits provision to more closely resemble the provisions in the pending Medicare Telehealth Parity Act would expand access and potentially resolve the current hurdles to telehealth adoption from the reimbursement perspective.

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[140] Adler-Milstein, *supra* note 40.
[141] *Id.*
[142] *Id.*
[143] Centers for Medicare & Medicaid Services, *Health Homes*, Medicaid.Gov, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html.
[144] Letter from Cindy Mann, Dir., Centers for Medicare & Medicaid Servs. 6 (Nov. 16, 2010), *available at* https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.
[145] *Id.*

V. Steps Toward Reform

The most effective and expeditious way to increase parity across state lines and between Medicare, Medicaid, and private-payer insurance platforms is congressional involvement. While reimbursement policies for telemedicine services have been slow to develop, the current Medicare and Medicaid structures provide a solid framework from which to develop the long overdue and much needed uniform and expansive reimbursement scheme. By passing the proposed Medicare Telehealth Parity Act[146] and amending the Essential Health Benefits provision of the Patient Protection and Affordable Care Act[147] to require reimbursement at parity for essential health benefits offered via telemedicine, Congress can greatly increase the rate of adoption and utilization of telemedicine in the United States.

In July 2015, Congress proposed the Medicare Telehealth Parity Act of 2015, which is designed to increase Medicare reimbursement for telehealth services over a four-year period.[148] Phase I will add additional qualifying originating sites and geographic areas, include services provided by additional categories of healthcare providers, and provide coverage for store-and-forward services.[149] Phase II will include a home telehealth site to the list of qualifying originating sites, and will again expand the program's geographic reach.[150] Phase III will extend the geographic reach to counties with populations above 100,000, and will provide for reimbursement of remote patient monitoring services for certain chronic care conditions.[151]

Passing the Medicare Telehealth Parity Act is vitally important to the increased adoption of telemedicine because only Congress can permanently modify or lift the geographic and

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[146] H.R. 2948, Medicare Telehealth Parity Act of 2015, 114th Congress (2015–16).
[147] 42 U.S.C. § 18022.
[148] Nathaniel Lacktman, *Congress Wows with Medicare Telehealth Parity Act of 2015, But Will it Succeed?*, Healthcare Law Today (July 15, 2015), http://www.healthcarelawtoday.com/2015/07/15/congress-wows-with-medicare-telehealth-parity-act-of-2015-but-will-it-succeed/; *see* H.R. 2948, *supra* note 68.
[149] *Id.*
[150] *Id.*
[151] *Id.*

practice setting limitations and approve the use of new technologies under the Medicare statute.[152] Using this proposed legislation as a benchmark, Congress can and should also update the federal Medicaid statute to expressly require that reimbursement for telehealth be paid at a rate equivalent to that of in-person services. Similarly, updating the Essential Benefits provision of the Affordable Care Act to include services rendered via telemedicine would require that all services covered in each state's benchmark plan be covered and reimbursed at parity to face-to-face healthcare, to the extent that those services are available via telemedicine.[153] Accordingly, because all plans cover preventative doctor visits, for example, all plans would be required to cover those visits if held via videoconferencing.[154] This approach is consistent with the notion that telemedicine as not itself a distinct benefit or service but simply another means of healthcare delivery.[155] Together, these minor changes at the federal level will result in a broad policy favoring telemedicine expansion because all insured individuals in the United States will have access to a significant variety of services offered through telemedicine.

A federal policy promoting increased adoption of telemedicine is preferable to state-driven expansion for two reasons. First, as discussed in Part III, *supra*, state law varies dramatically and those inconsistencies are largely the reason that the adoption of telemedicine far under-paces the promise of the technology.[156] Second, and more importantly, Medicare has historically been a leader in healthcare reimbursement policy, and is well poised to continue that role.[157] Most states and private insurance providers currently model their reimbursement

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[152] Adler-Milstein, *supra* note 40.
[153] *See* 42 U.S.C. § 18002 (requiring that all healthcare plans provide certain essential services).
[154] *See generally id.*
[155] Carl Benjamin Lewis, *Private Payer Parity in Telemedicine Reimbursement: How State-Mandated Coverage Can Be the Catalyst for Telemedicine Expansion*, U. Mem. L. Rev. 471, 473 (2015)
[156] *See* Part III, *supra.*
[157] Kristen Rabe Smolensky, *Telemedicine Reimbursement: Raising the Iron Triangle to a New Plateau*, 13 HEALTH MATRIX 371, 410–11 (2003).

schemes for telemedicine after the provisions in the federal Medicare statute, indicating that the market is already relying on the federal government for guidance in this area.[158]

State-driven expansion efforts are underway with the increased adoption of "private payer parity" statutes.[159] These laws require that private insurance companies reimburse services provided via telemedicine at the same rate as traditional services.[160] At present, however, only twenty-nine states and Washington D.C. have implemented private payer parity statutes.[161] Moreover, because of the lack of clarity and consistency of these laws and requirements, even to the extent that it is argued that states should lead the charge for telemedicine expansion it is agreed that a national consensus and more uniform legislative scheme is both necessary and long overdue.[162] State efforts towards expanding telemedicine availability to Medicaid patients have also been overwhelmingly unsuccessful from a national perspective. Of note, one recent study identified state wealth as a leading factor in telemedicine adoption through the Medicaid program.[163]

> Although telemedicine promises to be a cost-cutting strategy to state healthcare spending, high telemedicine start-up costs may prevent adoption in poorer states, limiting innovation in this policy area to wealthier states. . . . States without slack resources, mostly rural less-populous states, are less motivated to adopt policies with high startup costs. . . . Unfortunately, the[] poorer rural states have a greater population enrolled in Medicaid and need tele-Medicaid more than wealthier urbanized states.[164]

By contrast, the federal government has both the power and the foundation to implement a successful national policy.

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[158] *Id.*
[159] *See* Latoya Thomas & Gary Capistrant, *supra* note 83.
[160] *Id.*
[161] Am. Telemedicine Ass'n, *State Telemedicine Toolkit*, http://www.americantelemed.org/docs/default-source/policy/ata-state-telemedicine-toolkit-medical-boards.pdf.
[162] *See* Lewis, *supra* note 155(identifying many of the concerns associated with a fragmented reimbursement system and arguing for a "[s]tandardized adoption of [state] mandated private insurance laws").
[163] Mary Schmeida & Ramona McNeal, *State Policy Action on Medicaid Telemedicine Reimbursement Laws*, 5 Health Policy and Tech. 32, 35 (2016), *available at* http://dx.doi.org/10.1016/j.hlpt.2015.10.007.
[164] *Id.* at 35, 37.

The regulation of medicine and healthcare was traditionally local in nature.[165] But advances in medicine and medical technology, evidenced by the development of telemedicine and telehealth systems, has removed all local barriers to healthcare — patients are now, literally, treated by doctors across national and even international borders.[166] The federal government has recognized a need for national healthcare regulation in other contexts. For example, the Federal Drug Agency ("FDA") was created to address the health and safety concerns of an increasingly interstate medical community.[167] Beginning with the enactment of the Pure Foods and Drug Act in 1906, Congress implemented a health and safety policy through the national regulation of drugs.[168] Since passing the Pure Food and Drug Act, Congress has also passed the Federal Food, Drug, and Cosmetic Act of 1938, The Medical Devices Amendments of 1976, and various other expansive regulation designed to ensure the safe and efficient delivery of new medical technologies to the national public.[169]

Medicare has historically been Congress' primary vehicle for implementing widespread health care reimbursement policy.[170] For example, Medicare adopted a policy of payment based on diagnostic-related groups ("DRGs") in the 1980s.[171] The DRG payment model provides a fixed reimbursement amount based on a patient's diagnosis upon admission.[172] Under the DRG model, Medicare reimburses the hospital only that pre-defined amount, regardless of the patient's specific treatment or how long the patient remains in the hospital.[173] Thereafter, nearly two-

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[165] Amar Gupta & Deth Sao, *The Constitutionality of Current Legal Barriers to Telemedicine in the United States: Analysis and Future Directions of its Relationship to National and International Health Care Reform*, 21 Health Matrix 385, 407 (2011).
[166] *Id.* at 391.
[167] *Id.* at 409.
[168] *Id.*
[169] *Id.* at 410–12.
[170] Smolensky, *supra* note 157, at 410.
[171] CHARLES E. PHELPS, HEALTH ECONOMICS 379-82 (2d ed. 1997).
[172] *Id.*
[173] *Id.*

thirds of private-payer BlueCross BlueShield plans and twenty-one state Medicaid programs followed suit.[174] Similarly, Medicare began shifting to a resource-based, relative value scale model in the early 1990s.[175] Resource-based, relative value scales is a payment system that reimburses physicians according to their time and the complexity of their effort, regardless of the physician's specialty or the specific treatment provided.[176] Once again, nearly all BlueCross BlueShield plans began implementing the Medicare system.[177]

In the context of telemedicine, an examination of the various Medicaid programs and private payer policies, states and private insurance companies continue to follow Medicare's lead.[178] Blue Cross Blue Shield of Texas updated its telemedicine policy to reflect Medicare's restriction on services rendered via telephone conference only three months after the Medicare policy went into effect.[179] Kentucky's Medicaid statute also includes a nearly identical provision.[180] Medicare has proven to be a successful platform for influencing national healthcare payment structures and state telemedicine policies in the past, and holds the potential to be a key driving force in the continued expansion of telemedicine going forward.[181]

The Patient Protection and Affordable Care Act was designed, in large party, to achieve the equally important but somewhat conflicting goals of increased access to healthcare and reduced healthcare costs.[182] Under the ACA, all health plans are required to offer an "essential health benefits package."[183] The ACA directs:

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[174] Smolensky, *supra* note 157, at 410–11.
[175] *Id.* at 411.
[176] *Id.* at 411 n.164.
[177] *Id.*
[178] *Id.*
[179] *Id.*
[180] *Id.*
[181] *See generally* Smolensky, *supra* note 157.
[182] *See* Gupta & Sao, *supra* note 165 at 386.
[183] *See* 42 U.S.C. § 18022.

> [T]he Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:
> (A) Ambulatory patient services;
> (B) Emergency services;
> (C) Hospitalization;
> (D) Maternity care;
> (E) Mental health and substance use disorder services, including behavioral health treatment;
> (F) Prescription drugs;
> (G) Rehabilitative and habilitative services and devices;
> (H) Laboratory services;
> (I) Preventative and wellness services and chronic disease management; [and]
> (J) Pediatric services, including oral and vision care.[184]

Thus, nearly all of the essential health benefits are available to some extent via telemedicine platforms.[185] Accordingly, a minor amendment to the ACA, expressly requiring reimbursement of essential benefits would rapidly and dramatically increase access to telemedicine for the millions of Americans covered under private health plans subject to the ACA's essential health benefits benchmark.[186]

CONCLUSION

By passing the Medicare TeleHealth Parity Act[187] and amending the Essential Health Benefits provision of the Affordable Care Act, Congress will articulate the broad federal policy needed to finally and fully unlock telemedicine's ability to better connect an increasingly technology-driven healthcare system with its real potential to increase access to healthcare, improve patient outcomes, and lower healthcare delivery costs across the United States.[188]

Telemedicine is the key to realizing many of the most important health policy goals identified in the Patient Protection and Affordable Care Act: access to care, quality of care, and

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[184] 42 U.S.C. § 18022(b)(1)(A)-(J).
[185] *See* Weinstein et al, *supra* note 30 and related discussion.
[186] PRESS RELEASE, *Health Coverage Grows Under Affordable Care Act*, The Rand Corporation, (May 15, 2015) http://www.rand.org/news/press/2015/05/06.html (estimating an increase of 16.9 million insured Americans newly insured as a result of the ACA).
[187] H.R. 2948, *supra* note 146.
[188] *See* discussion, *supra* Part III.

cost-effectiveness. Presently, reimbursement for telemedicine services is a significant hurdle to widespread telemedicine adoption. The patchwork of reimbursement schemes across states and insurance platforms will continue to undermine the success of telemedicine, but minor changes to Medicare and the ACA Essential Health Benefits provisions at the federal level would more clearly define a reimbursement scheme for telemedicine and facilitate a more rapid expansion of telemedicine services.